PLEASE PRINT CLEARLY

DATE ______________ REFERRED BY ______________________________

PATIENT NAME ____

DATE OF BIRTH ____________ AGE ________ SEX ________ MARITAL STATUS ____________

LOCAL ADDRESS ____

CITY ______________________ STATE ______________ ZIP CODE ____________

HOME # ______________ CELL # ______________ WORK # ______________

EMPLOYER ______________________ SOCIAL SECURITY # ______________

NORTH ADDRESS ____

CITY ________________ STATE ________ ZIP CODE ________ PHONE # ____________

NAME OF SPOUSE ________________ SPOUSE'S EMPLOYER ________________

RESPONSIBLE PARTY ________________ SOCIAL SECURITY # ________________

PLEASE READ CAREFULLY AND SIGN BELOW

My signature on this form authorizes the release of any information relating to all claims for benefits on behalf of myself or my dependents. I further agree and acknowledge that my signature on this document authorizes Dr. Richey to submit claims for benefits, for services rendered, without obtaining my signature on each and every claim, to be submitted for myself and my dependents.

I understand that payment is expected at the time of service (non-Medicare patients), and I agree to be fully responsible for my, or my minor children's, charges.

I also understand that I am responsible for any collection costs, should such action become necessary.

I understand that Dr. Richey is not a Worker's Compensation provider, and therefore, does not treat Worker's Compensation related problems.

MEDICARE PATIENTS

I understand that I am responsible for the annual deductible and the 20% copayment. I understand that, as a courtesy, my secondary insurance will be filed. However, in the event that the secondary insurance does not pay within 60 days, I will be billed for the 20% copayment.

Please present your Medicare and secondary insurance cards to the receptionist upon completion of this form.

____

PATIENT OR RESPONSIBLE PARTY'S SIGNATURE

MEDICAL HISTORY

FAMILY DOCTOR ____________________

MEDICATIONS ____________________

____

____

OVER THE COUNTER MEDICATIONS (VITAMINS, SUPPLEMENTS, HERBALS, ANTACIDS, LAXATIVES) ____________________

ALLERGIES TO MEDICATIONS ____________________

____

MEDICAL HISTORY ____________________

____

____

____

____

DO YOU HAVE ANY OF THE FOLLOWING: (Please circle)

ANEMIA

ANGINA

ARTIFICIAL JOINT

ARTHRITIS

ASTHMA

BLEEDING PROBLEMS

BLOOD THINNER

BLOOD DISORDER

DEFIBRILLATOR

DIABETES

ECZEMA

HAY FEVER

HEART VALVE

HEPATITIS

HIV/AIDS

MITRAL VALVE PROLAPSE

PACEMAKER

PSORIASIS

SUN SENSITIVITY

THYROID TROUBLE

SKIN CANCER: Basal cell carcinoma, squamous cell carcinoma, melanoma

RECORDS RELEASE AUTHORITY

I hereby request that, if necessary, Hobart K. Richey, M.D., provide verbal and/or written information, pertaining to my medical condition and/or treatment, to:

NAME OF INDIVIDUAL	RELATIONSHIP TO PATIENT
NAME OF INDIVIDUAL	RELATIONSHIP TO PATIENT
NAME OF INDIVIDUAL	RELATIONSHIP TO PATIENT
NAME OF INDIVIDUAL	RELATIONSHIP TO PATIENT
NAME OF INDIVIDUAL	RELATIONSHIP TO PATIENT
NAME OF INDIVIDUAL	RELATIONSHIP TO PATIENT

I understand that no information will be provided to family members, including spouses, unless their name appears above. I also understand that this release of information shall remain in effect until I provide written notification of changes.

PATIENT'S SIGNATURE

DATE